

Case Number:	CM14-0044091		
Date Assigned:	07/02/2014	Date of Injury:	01/02/1993
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/11/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 69 year old male who reported an injury on 01/02/1993 due to an unknown mechanism. The diagnosis was multilevel lumbar spine discopathy, status post thoracic spine surgery. Past treatment plans for the injured worker were 2 spinal surgeries. No other conservative care was noted. Diagnostic studies were not submitted for review. A request for an updated MRI scan of the lumbar spine was submitted. The injured worker has had 2 spinal surgeries in the past. There were no subjective complaints noted. Physical examination on 06/04/2014 revealed complaints of neck, back pain. The injured worker rated his pain of the upper back at 3/10 on the pain scale. He also had complaints of aching and stabbing pain in the low back which was rated at 5/10. The injured worker had complaints of aching pain in the right elbow, aching pain in the left ribs which he rated at 2/10. There were complaints of pain in the bilateral feet with numbness which was rated at 1/10 and pain in the lower extremities with mild numbness and tingling. Lumbar spine examination revealed there was slight flattening of the lumbar lordosis. Palpation revealed tenderness in the paraspinous musculature of the lumbar region. Midline tenderness was noted in the lumbar region. Muscle spasm was negative. Range of motion for the lumbar spine with active cooperation and effort revealed flexion was to 20 degrees, extension was to 15 degrees, right rotation was to 15 degrees, left rotation was to 10 degrees, tilt right was to 15 degrees, tilt left was to 15 degrees. Sensory testing revealed pinwheel testing was slightly abnormal. Motor strength examination was essentially normal. Current medications were Voltaren, Tylenol No. 3 and Benazepril, Ketoprofen cream. The treatment plan was to request an MRI of the lumbar spine, request 8 visits of acupuncture and continue with medications as prescribed. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Ketoprofen 20% cream #240 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111,112.

Decision rationale: The MTUS Chronic Pain Guidelines states that topical analgesics are an option. They are largely experimental in use with few randomized trials. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Topical Ketoprofen is not currently FDA approved for a topical application. Although the injured worker has reported pain relief and functional improvement from the use of this medication, the provider did not indicate a frequency or area of the body the medication would be applied to. Therefore, the request is not medically necessary and appropriate.

Acupuncture X 12: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS Chronic Pain Guidelines states the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as time to produce functional improvement of 3 to 6 treatments. The suggested frequency is 1 to 3 times per week, with an optimum duration of 1 to 2 months with functional improvement documented. The injured worker has had several acupuncture treatments with no noted measurable gains in functional improvement reported. Therefore, the request is not medically necessary and appropriate.